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CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 15.7
TITLE: CONSULTATIONS

AUTHORITY: 38 CFR 17.270(a) and 17.272(a)

RELATED AUTHORITY: 32 CFR 199.4 (c)(2)(vi)

I. EFFECTIVE DATE

January 1, 1992

II. PROCEDURE CODE(S)

99241-99275

III. DESCRIPTION

A consultation is a type of service provided by an authorized provider whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another authorized provider. The attending physician's request and the need for consultation must be provided for the patient's permanent medical record. The consultant's opinion, along with any services that were ordered or performed, must also be documented in the patient's record and communicated to the requesting provider.

IV. POLICY

A. Consultations performed by an authorized individual professional provider at the request of the patient's attending provider are covered.

B. The four subcategories of consultation are as follows:

1. Confirmatory
2. Follow-up inpatient
3. Inpatient
4. Office

C. The level of services provided within each of these subcategories is based on the following factors:

1. History
2. Examination
3. Medical decision making
4. Counseling
5. Coordination of services
6. Nature of presenting problem
7. Time

D. Payment for initial consultations may be made when billed with a surgical procedure performed on the same date of service.

E. Reimbursement for a consultation does not include diagnostic procedures performed by the consultant. Appropriate allowances should be made for such services in addition to the consultation.

V. POLICY CONSIDERATIONS

A. Only one initial or confirmatory consultation is covered when provided by the same provider during the course of the patient's illness, meaning for the same diagnosis, or episode of illness. Any other initial or confirmatory consultations for this same episode of illness will be denied.

B. Consultations by providers of the same or different specialties are covered when required because of a complex medical condition.

C. In order to be processed, the consult must contain the name and address of the provider.

D. Consultations will be cost shared according to the status of the patient, inpatient or outpatient, at the time the service is rendered.

E. After a consultation has occurred and when the provider begins treatment of the patient (assumes responsibility for management of a portion or of all the patient's condition), the appropriate CPT procedure code(s) for the treatment should be used in lieu of the consultation code(s).

F. When a consultation is performed within three days of a surgical procedure by the same provider, the consultation fee is included in the global surgical fee.

VI. EXCLUSIONS

A. Telephone consultations and telephone toll charges.

B. Staff consultations required by the policies of a hospital or other institution.

C. Routine telephone calls from a physician to a patient or from a patient to a physician.

END OF POLICY